Universal 17-P Authorization Form

***Fax the COMPLETED form OR call the plan with the requested information.**

☐ **Absolute Total Care**	☐ **BlueChoice HealthPlan**	☐ **First Choice by Select Health**	☐ **WellCare of South Carolina**
P: 803-933-3689	P: 866-902-1689	P: 888-559-1010 x55251	P: 888-588-9842
F: 866-918-4451	F: 800-823-5520	F: 866-533-5493	F: 866-458-9245

Date of Request for Authorization _____

Patient/Member Name _____ DOB _____
First Middle Last

Address (Street, Apt.#) _____ City/State/Zip _____

Phone _____ Medicaid Number _____ MCO ID Number _____

☐ Pregnancy Information and History

G___ T___ P___ A___ L___ (Note: A= abortion (spontaneous and medically induced) EDC _____

Last menstrual period _____ EDD _____ Current Gestational age _____ weeks

Bed Rest ☐ Yes ☐ No Experiencing Preterm Labor ☐ Yes ☐ No
(Home administration available if on bed rest)

☐ Singleton Pregnancy ☐ Multiple Pregnancy

At least 16 weeks gestation ☐ Yes ☐ No Major Fetal or Uterine Anomaly ☐ Yes ☐ No

Patient has a history of prior spontaneous singleton preterm birth between 20-36.6 weeks ☐ Yes ☐ No

Delivery was due to preterm labor or PPROM even if it resulted in C-section ☐ Yes ☐ No

Delivery was not due to medical indication, e.g. preeclampsia, abruption, etc. ☐ Yes ☐ No

Medication Allergies _____ ☐ No known drug allergies

Other Pertinent Clinical Information: _____

_____

☐ Pharmacy Information

☐ Ship to patient's home address End Date of Service _____

☐ Ship to provider's address End Date of Service _____

Shipping Preference: ☐ Regular Mail ☐ Ground ☐ Overnight

Ordering Physician's Signature: _____

☐ Provider Information

Ordering Provider Name _____
(Please Print)

Ordering Provider NPI _____ Tax ID _____

Address _____ City/State/Zip _____

Phone _____ Fax _____

Provider Type: ☐ OB/GYN ☐ Family Medicine ☐ MFM/Perinatology ☐ Other _____

Practice Name: _____ Practice NPI: _____

Contact Person: _____ Phone: _____ _____

FOR MCO USE ONLY:

☐ Approved ☐ Denied Authorization # _____ Number of Injections _____

Date of Notification to Provider: _____.Reviewer(s) name & title: _____ ___

Please note that our review applies only to the authorization of medical necessity and benefit coverage. This authorization is not a guarantee of payment unless the member is eligible at the time the services are rendered.